PRINTED: 08/26/2010
FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GLASGOW HEALTH & REHABILITATION CENTER	220 WESTWOOD ST. GLASGOW, KY 42141

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on August 10-12, 2010. Deficient practice was identified with the highest scope and severity at "F" level.	F 000	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
F 156 SS=B	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services.	F 156	F-156 1. The notice was amended to include the reason the services were non-covered 9/7/2010. The amended letters will be sent to residents #4, #5, #16, and #17 return receipt requested or family will sign or will be contacted by phone and document on a form by 9/10/2010. 2. All notices of Medicare Provider Non-Coverage for last 6 months will be reviewed and appropriate amendments made & family/responsible party notified by 9/17/2010. 3. Policy reviewed with Book keeper by Administrator on 8/13/2010. 4. All notices to be reviewed X6 months by administrator prior to issue to ensure reason is noted and upon return to ensure that family/responsible party notification is documented. 5. Date of Completion: 9/17/2010.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Danielle T, Adm | TITLE: Administrator | (X6) DATE: 9-7-2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and	F 156		

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F 156	Continued From page 2 provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement the requirements of the demand billing process regarding the Notice of Medicare Provider Non-Coverage. The Notice letter failed to include the specific reason the services were non-covered and failed to include the verification of receipt of the Notice for five (5) of five (5) reviewed Notice letters (residents #4, #5, #14, #16, and #17). The findings include: A review on August 12, 2010, at 3:30 p.m., of the denial notices for Non-Medicare coverage for residents #4, #5, #14, #16, and #17 revealed the	F 156		

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F 156	Continued From page 3 notices of non-coverage provided to the resident/responsible party failed to include the specific reason the services were not covered. Further review revealed the facility could not verify the specific date the notice was mailed or when the resident/responsible party had received the notice. An interview conducted with the Bookkeeper on August 12, 2010, at 3:30 p.m., revealed the Bookkeeper was responsible for issuing the denial notices to the residents/responsible parties. The Bookkeeper stated the denial notices were mailed to the resident/responsible party within 48 hours prior to the end of the Medicare coverage date. However, the facility had no documented evidence to verify that the Notices had been received.	F 156	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and	F 225	F-225 1. We cannot correct the non-compliance in this situation but the allegation was investigated and our report is available for review. 2. All allegations made for the 6 months are being reviewed to ensure that appropriate agencies were notified. We will also conduct interviews with alert & oriented residents, interview the resident council, and review all incident reports for past 6 months by 9/20/2010. This will be completed by 9/20/2010 by Social Services, Activity Director, and Nursing Administration to ensure that no other allegations are found. 3. An in service for all staff to be conducted on 9-11-10 by DON regarding Abuse policy. Abuse policy to be reviewed with all new hires effective immediately and in-service to be repeated no less than annually. All allegations are to be reviewed with Administrator and DON who will report all allegations to the appropriate agencies per our policy.	

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F 225	Continued From page 4 to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure all allegations of abuse, neglect, or mistreatment involving resident to resident altercations were reported immediately to the appropriate state agencies for one (1) of twenty (20) sampled residents. On June 28, 2010, resident #1 reported to the resident's responsible party (RP) that another male (resident #19) had hit resident #1. The facility conducted an investigation into the alleged incident, however, there was no evidence the allegation had been reported to the appropriate state agencies. The findings include: Resident #1 was observed on August 10, 2010, at 12:50 p.m., to be sitting up in a chair next to the	F 225	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies.* *Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* 4. All allegations of abuse will be reviewed by the facility QA committee to ensure appropriate notification of agencies, family/responsible parties and physicians. 5. Date of Completion:	9/20/2010

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F 225	Continued From page 5 resident's bed, listening to music. The resident stated the resident had a fight with the male resident who shared the same bathroom with resident #1. Resident #1 stated the resident had tried to come into the bathroom while resident #1 was present. Resident #1 stated the resident had threatened to kill resident #1. Further observation conducted on August 10, 2010, at 6:45 p.m., revealed resident #1 was lying on the bed and stated, "That man tried to come in the bathroom again on me today." An interview conducted with CNA #1 on August 10, 2010, at 3:45 p.m., revealed resident #1 had reported being hit by resident #19 approximately three weeks ago. CNA #1 stated resident #1 and resident #19 shared the same bathroom facilities and resident #1 believed the other male resident was trying to enter the bathroom when resident #1 was using the bathroom facilities. An interview conducted with CNA #2 on August 11, 2010, at 2:10 p.m., revealed resident #1 had reported that resident #19 had come into resident #1's room and grabbed resident #1. CNA #2 stated this occurred approximately one month ago and was reported to the charge nurse. The CNA could not recall the name of the charge nurse. A review of the facility's investigation dated June 28, 2010, revealed resident #1's family member had reported that resident #1 was hit by another male resident. The investigation noted resident #1 had locked the bathroom door shared by the two residents and resident #19 had gone into resident #1's room to unlock the bathroom door. The investigation noted resident #19 took resident #1 by the arm; however, resident #19's normal	F 225		

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F 225	Continued From page 6 behavior was to touch other people. The investigation further noted resident #1 reported to the Social Services Director (SSD) that resident #19 came into the resident's room and was cursing resident #1. An interview conducted with the Director of Nurses (DON) on August 12, 2010, at 4:00 p.m., revealed the DON had conducted an investigation into the alleged incident on June 28, 2010, and could not determine resident #1 had been hit by resident #19. The DON stated the alleged abuse was not reported to the state agencies since no physical contact had been alleged. A review of the facility's Abuse policy (dated February 5, 2003) revealed residents should not be subjected to abuse by anyone including, but not limited to, facility staff, other residents, family members, or other individuals. The policy defined "verbal abuse" as the use of oral, written, or gestured language that willfully included disparaging and derogatory terms to the residents. The policy noted examples of verbal abuse included threats of harm and saying things to frighten a resident. The policy further noted the investigation into the alleged abuse would be submitted to the appropriate state agencies within five working days and all alleged violations were required to be reported to all agencies as required.	F 225	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* F-246 1. We cannot correct the alleged non-compliance in the past. 2. All smokers in the building have the potential to be affected by the past alleged non compliance. 3. The facility is investigating the options available but until a permanent solution is found we will provide a tent covering in the courtyard for when it is raining or snowing and will put fans in the Courtyard area to keep air moving in case of excessive heat. 4. The administrator & DON will monitor the need for the canopy when the weather is inclement to ensure the rights of the residents who smoke are honored. 5. Date of Completion: 9/20/2010	
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be	F 246		

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F 246	Continued From page 7 endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide reasonable accommodation of individual needs and preferences for eight (8) residents (resident #6 and seven (7) unsampled residents) regarding smoking accommodations. A new city ordinance prohibited residents from smoking on the front porch of the facility and, as a result, residents were required to smoke in the uncovered courtyard. According to the National Weather Service, temperatures ranged from the mid to upper nineties with an elevated heat index. However, there was no evidence the facility had provided accommodations for shelter for the residents who chose to smoke. The findings include: An individual interview conducted with resident #6 on August 10, 2010, at 4:00 p.m., revealed the resident was informed upon admission to the facility that smoking was permitted either on the front porch or the courtyard of the facility. Resident #6 stated after a new city ordinance was passed a "few months ago" the residents were no longer allowed to smoke on the front porch and were required to smoke in the courtyard. The resident stated during inclement weather the residents could not smoke because the courtyard was not covered. In addition, resident #6 stated the temperatures had been very hot for the past several weeks when the residents had to go to the courtyard to smoke.	F 246		

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F 246	Continued From page 8 Residents were observed to smoke outside in the courtyard during the survey conducted on August 10-12, 2010. The courtyard was observed to be uncovered with concrete flooring. A single patio table was observed with one umbrella provided. The front porch was noted to be a fully covered area. A small tree was observed to provide only minimal shade for one resident. Interviews were conducted on August 12, 2010, at 12:15 p.m., with five residents who were in the courtyard smoking. The residents stated it was very hot outside when they were smoking. The residents also stated they would not be able to smoke when it rained or snowed. An interview conducted with the Social Services Director (SSD) on August 11, 2010, at 3:00 p.m., revealed residents or the responsible party (RP) were provided with information related to smoking when the resident was admitted to the facility. The SSD stated the residents/RP had been informed of the scheduled smoke breaks and that smoking was permitted either on the front porch or in the courtyard. The SSD stated after the ordinance was passed approximately two months ago, residents were informed they would only be permitted to smoke in the courtyard. A review of city ordinance #2688 dated March 22, 2010, revealed smoking was prohibited in all enclosed public places. The ordinance defined a public place as an enclosed area to which the public is invited or in which the public is permitted, including, but not limited to banks, educational facilities, health care facilities, hotels/motels, restaurants, and retail stores. The ordinance further noted that smoking was prohibited within	F 246		

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F 246	Continued From page 9 15 feet of the main outside entrance for the public to any enclosed area. A review of the local newspaper (Glasgow Daily Times) published on August 4, 2010, revealed "this summer was one of the hottest summers Kentucky has experienced in nearly 60 years." The newspaper further stated temperatures for June and July 2010 had soared to the mid-to-high nineties and the number of days with afternoon highs at or above 90 degrees in June and July was the highest on record since 1952. The newspaper further noted the temperatures for August 2010 continued to be above normal. An interview conducted with the facility Administrator on August 12, 2010, at 1:45 p.m., revealed the ordinance had been in the planning stage in March 2010 and had gone into effect in June 2010. The Administrator stated the residents had been directed to smoke in the courtyard. The Administrator stated the temperatures had been elevated and some rain storms had occurred since the ordinance had been enforced. The Administrator also stated the administrative staff had discussed concerns related to the residents having to smoke outside in the uncovered area; however, no action plans had been developed/implemented to provide shelter for the residents who smoke.	F 246	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* F-250 1. A stop sign was placed on resident #1's doorway on 8-13-10 to deter entrance into the room by other resident. Resident #19 was moved a different room 9-3-10. 2. Social Services spoke with resident #1 on 9-3-10 to ensure no further altercation/problems have occurred with resident #19. No incidents were reported. Will review all incident reports for past 6 months to identify any other resident to resident altercations that may have occurred by 9/20/2010. The care plan for resident #19 was reviewed to ensure plans in place to prevent any further resident to resident altercations.	
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.	F 250	3. Social Services will follow up with resident #1 and resident #19 weekly to ensure that all social services needs are being met. This will be documented in the	

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F 250	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that medically-related social service needs had been provided for one (1) of twenty (20) sampled residents. Resident #1 had a history of increased agitation toward a past roommate, as well as verbal and physical behaviors, and required a psychiatric hospital stay in December 2009. On June 28, 2010, a resident-to-resident altercation occurred between resident #1 and resident #19. There was no evidence the facility had identified the medically-related social service needs of the resident and no evidence the facility had monitored the resident to ensure further problems/altercations did not reoccur with resident #1 (refer to F225). The findings include: A review of the medical record revealed resident #1 was admitted to the facility on February 5, 2007, with diagnoses to include Senile Dementia, Secondary Parkinsonism, Depression, Anxiety, and Dementia with Behaviors. A review of the comprehensive assessment completed on March 19, 2010, revealed the resident was assessed to have short-term memory loss with modified independence with decision-making skills. Resident #1 was assessed to have no mood or behavioral symptoms. An interview conducted with resident #1 on August 10, 2010, at 12:50 p.m., revealed the resident reported having a fight with a male resident who resided next door. Resident #1 stated the other male resident came into the	F 250	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* social services notes. In addition social services will review any incident between residents and follow up weekly X4 weeks then as necessary to ensure appropriate plans are in place to prevent or minimize any incidents. 4. Corporate Social Services consultant will review social services notes related to any resident to resident altercations monthly X6 months to ensure appropriate follow up. This review will be presented to the facility QA committee for review. 5. Date of Completion: 9/20/2010	

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F 250	Continued From page 11	F 250		

bathroom and told resident #1, "I'll kill you." Resident #1 stated the resident (#1) was not injured during the altercation. At 6:45 p.m., resident #1 was observed to be lying on the bed with the rolling walker beside the bed. The resident stated, "That man tried to come in the bathroom on me again." Resident #1 stated he was not afraid of the other resident, but indicated the rolling walker would keep the other resident away from him.

A review of the facility's investigation dated June 28, 2010, revealed resident #1's family member had reported that resident #1 was hit by another male resident. The investigation noted resident #1 had locked the bathroom door shared by the two residents and resident #19 had gone into resident #1's room to unlock the bathroom door. The investigation noted resident #19 took resident #1 by the arm; however, resident #19's normal behavior was to touch other people. The investigation further noted resident #1 reported to the Social Services Director (SSD) that resident #19 came into the resident's room and was cursing resident #1. The investigation noted that a room change was offered to resident #1; however, the resident did not want to move. A note was placed on the bathroom door to remind resident #1 to lock/unlock the bathroom door when using the facilities to keep resident #19 out of resident #1's room.

A review of the social services progress notes dated December 15, 2009 through June 11, 2010, revealed the Social Services Director (SSD) assessed resident #1 to have no mood or behavioral problems. In addition, the SSD progress notes contained documentation of routine visits by the psychiatrist. However, there

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F 250	Continued From page 12 was no documentation related to the resident-to-resident altercation involving resident #1 and resident #19 on June 28, 2010. In addition, there was no evidence the SSD had monitored for the possibility for potential additional altercations between residents #1 and #19. An interview conducted with the SSD on August 11, 2010, at 3:00 p.m., revealed the SSD was aware of the resident-to-resident altercation between residents #1 and #19 on June 28, 2010. The SSD stated he/she had participated in the initial investigation but had not talked with resident #1 since the alleged incident. The SSD stated the SSD failed to determine if the intervention of placing the sign on the bathroom door had resolved the conflict between the two residents. The SSD stated he/she reviewed the behavior logs prior to completion of the comprehensive assessments. The SSD further stated he/she should have documented and followed up to determine if the conflict had resolved or if additional incidents had occurred.	F 250	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.* *Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated.* *To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.*	
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and	F 274	F – 274 1. A significant change will be completed on residents #2, #4, and #6 by 9/14/2010. 2. A facility audit will be completed by 9/20/2010 on all in-house residents from the last full assessment to determine if a significant change was indicated by DON and or MDS Coordinator. Those that are found to be indicated will be checked to see if a significant change assessment was completed. All Interdisciplinary team members will be re-educated by DON on the criteria for significant change assessments 9/10/2010. 3. The Nursing awareness meeting will be updated by 9/17/2010 to include discussion of any changes in the resident's condition on a weekly basis that would potentially prompt the need for a significant change assessment. The Care Plan meetings will also include a discussion by the interdisciplinary team members regarding resident conditions that would potentially prompt the need for a significant change assessment.	

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F 274	Continued From page 13 requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to identify and conduct a comprehensive minimum data set (MDS) significant assessment for three (3) of nineteen (19) sampled residents after the residents experienced a significant change in condition. Resident #2 sustained a decline in the development of a Stage II pressure sore, a gastrostomy tube (G-tube) placement, the use of an indwelling catheter, and a decline in functional range of motion (ROM). Resident #4 sustained a decline in the development of a Stage IV pressure sore, bowel and bladder incontinence, and functional range of motion. Resident #6 was identified to have a decline in bowel/bladder function, a weight increase, and newly implemented psychotropic medications; however, the facility failed to conduct a significant change comprehensive assessment for further evaluation of these changes for these residents. The findings include: 1. A review of the medical record revealed resident #2 was admitted to the facility on March 13, 2007, with diagnoses to include Moderate Mental Retardation, Hypertension, Depression, Anxiety, Seizure Disorder, Congestive Heart Failure, Diabetes, Organic Brain Syndrome, and Dysphasia. A review of a quarterly MDS assessment dated December 21, 2009, for resident #2 revealed the	F 274	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* 4. The DON will audit 24 hr report on weekly basis for any resident that has had a significant change in condition and will review to determine if should have had a significant change assessment and if so, was it completed. Will report findings to QA committee quarterly x6 months. 5. Date of Completion:	9/20/2010

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F 274	Continued From page 14	F 274		

resident's skin was intact, consuming food and fluids by mouth, totally incontinent of the bladder with no use of an indwelling catheter, and had no limitations in functional range of motion. A review of the quarterly assessment completed on March 26, 2010, revealed resident #2 developed a Stage II pressure sore, had a gastrostomy tube (G-tube) placement, required the use of an indwelling catheter, and had a decline in functional range of motion (ROM). However, there was no evidence the facility had identified and conducted a significant assessment when resident #2 was assessed to have changes during the March 26, 2010 assessment. As a result, the facility failed to further evaluate the possible causal/risk factors to address the changes in resident #2's development of a pressure sore, the placement of a G-tube, the use of an indwelling catheter, and a decline in functional ROM.

An interview conducted with the Director of Nursing (DON) at 5:30 p.m. on August 12, 2010, revealed the RN who conducted the March 26, 2010 quarterly assessment was no longer employed by the facility. However, the DON stated a significant change assessment should have been completed instead of a quarterly assessment for the March 26, 2010 assessment.

Observation of resident #2 at 12:00 p.m. Central Daylight Time (CDT) on August 10, 2010, revealed the resident was up in a wheelchair in the resident's room. Further observation revealed resident #2 received nutrition via enteral gastrostomy tube (G-tube) feedings and had an indwelling catheter in place.

2. A review of the medical record revealed resident #4 was admitted to the facility on May

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F 274	Continued From page 15 11, 2009, with diagnoses to include Gastroesophageal Reflux, Hypertension, Aphasia, Dysphasia, Diabetes, Chronic Renal Failure, and Encephalopathy. A review of an annual comprehensive MDS assessment completed on May 4, 2010, for resident #4 revealed the resident's skin was intact, occasionally incontinent of bowel and bladder, and had no limitations in functional range of motion (ROM). A review of the quarterly MDS assessment completed on July 29, 2010, revealed resident #4 developed a Stage IV pressure sore, was totally incontinent of bowel and bladder, and had a decline in functional ROM. However, there was no evidence the facility identified and conducted a significant change assessment when resident #4 was assessed to have changes during the July 29, 2010 assessment. As a result, the facility failed to further evaluate the possible causal/risk factors to address the changes in resident #4's development of a pressure sore, decline in bowel/bladder function, and a decline in functional ROM. An interview conducted at 5:30 p.m. on August 12, 2010, revealed that the former RN responsible for the MDS assessment was no longer employed by the facility. Therefore, the DON completed the July 29, 2010 quarterly assessment. The DON stated that she/he had not had time to compare the previous MDS assessments, and a significant change assessment should have been conducted instead of a quarterly assessment for the July 29, 2010 assessment for resident #4. 3. A review of the medical record revealed	F 274		

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F 274	Continued From page 16 resident #6 was admitted to the facility on September 30, 2009, with diagnoses to include Cerebral Vascular Accident (CVA), Diabetes Mellitus Type II, Chronic Renal Failure, Depression, and Peripheral Vascular Disease (PVD). A review of the admission comprehensive assessment completed on October 7, 2009, revealed resident #6 was assessed to be continent of bowel and occasionally incontinent of bladder. The resident was also assessed to have sustained no falls, to have no weight changes, and to be receiving no psychotropic medications. A review of the quarterly assessment completed on March 16, 2010, revealed resident #6 was totally incontinent of bowel and bladder and had sustained falls in the past 31 to 180 days. In addition, resident #6 was assessed to have experienced a significant weight gain and had received an antidepressant medication for seven days during the assessment reference period. Further review of the quarterly assessment completed on June 16, 2010, revealed resident #6 remained totally incontinent of bowel and bladder, continued to have weight gain and falls in the past 30 days and in the past 31 to 180 days. The resident was also assessed to continue to require an antidepressant medication. However, there was no evidence the facility had conducted a significant change assessment when resident #6 was assessed to have changes during the March 16, 2010 and the June 16, 2010 assessment. As a result, the facility failed to further evaluate the possible causal/risk factors to address the changes in resident #6's elimination function, falls, weight gain, or use of psychotropic medications.	F 274		

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F 274	Continued From page 17 Resident #6 was observed on August 10, 2010, at 12:45 p.m., to be sitting in a wheelchair in the resident's room. The resident was observed to be dressed in personal clothing and to be wearing disposable briefs. Resident #6 was also observed during the evening meal on August 10, 2010, at 6:10 p.m., to consume 75-100 percent of the meal served. An interview conducted with resident #6 on August 12, 2010, at 2:10 p.m., revealed the resident was not always aware of the urge to void/defecate. The resident stated incontinence briefs were used due to incontinence when not getting to the bathroom in time. Resident #6 stated staff would respond timely when the resident used the call light to inform staff of the need to toilet. An interview conducted with RN #3 on August 12, 2010, at 2:50 p.m., revealed the RN who conducted the March 16, 2010 quarterly assessment was no longer employed by the facility. RN #3 stated he/she had completed the June 16, 2010 assessment; however, RN #3 stated he/she did not compare the assessment to the admission assessment and did not identify that a significant change assessment was indicated for resident #6. RN #3 stated bowel/bladder assessments were completed quarterly and resident #6 had been on a scheduled toileting program in December 2009, but had refused to cooperate with the program. RN #3 stated no further interventions had been attempted.	F 274	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* F-279 1. The care plans for resident #6 were reviewed and updated to ensure all care areas were addressed including the change in condition. 2. The interdisciplinary team will systematically review all care plans by 9-16-10 to ensure that all care areas are addressed. All care plans will be updated as necessary to reflect the current needs of residents. 3. All care plans will be updated when there is a significant change in condition or change in treatment for any changes such as our falls management program, bowel & bladder assessments, skin assessments, NAR meeting, pain management program. Facility will also review all physicians' orders daily to ensure changes in treatment are noted timely. 4. The MDS Coordinator will review 10 care plans weekly to ensure that changes are being made to the	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

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F 279	Continued From page 18 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to use the results of the assessment to develop a comprehensive plan of care for one (1) of twenty (20) sampled residents. Resident #6 was assessed to have sustained falls, to have a decline in bowel/bladder function, to have a significant weight gain, and to require the use of psychotropic medications. However, there was no evidence the facility had developed an individualized care plan to address these changes in resident #6's status (refer to F274). The findings include: Resident #6 was observed on August 10, 2010, at 12:45 p.m., to be sitting in a wheelchair in the	F 279	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* care plans as needed. Her reviews will be presented to the facility QA committee no less than quarterly for one year. 5. Date of Completion: 9/16/2010	

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F 279	Continued From page 19 resident's room. The resident was observed to be dressed in personal clothing and to be wearing disposable briefs. A review of the admission assessment completed on October 7, 2009, revealed resident #6 was assessed to require extensive assistance of staff for bed mobility, transfers, toileting, and dressing. The resident was also assessed to be continent of bowel and occasionally incontinent of bladder and to have no fall history. In addition, resident #6 was assessed to have no weight changes and to be receiving no psychotropic medications. A review of the quarterly assessment completed on March 16, 2010, revealed resident #6 was totally incontinent of bowel and bladder and had sustained falls in the past 31 to 180 days. In addition, resident #6 was assessed to have experienced a significant weight gain and had received an antidepressant medication for seven days during the assessment reference period. Further review of the quarterly assessment completed on June 16, 2010, revealed resident #6 remained totally incontinent of bowel and bladder, continued to have weight gain and falls in the past 30 days and in the past 31 to 180 days. The resident was also assessed to continue to require an antidepressant medication. A review of the comprehensive care plan dated October 7, 2009, revealed no evidence the facility had developed an individualized plan of care to address the decline in the resident's bowel/bladder function and the resident's weight gain. In addition, the facility failed to develop a plan of care to address the resident's need for an antidepressant medication. Further review of the comprehensive care plan	F 279		

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F 279	Continued From page 20 dated October 7, 2009, revealed the facility did identify resident #6 to be at risk for falls related to unsteady gait with the use of a left leg prosthesis. However, there was no evidence the facility had developed care plan interventions to address additional fall risks for resident #6 after the resident sustained falls on February 13, 2010 and May 24, 2010, as a result of leaning forward from the wheelchair. An interview conducted with RN #3 on August 12, 2010, at 2:50 p.m., revealed he/she had reviewed resident #6's care plan after the June 16, 2010 assessment was completed. The RN stated he/she did not identify the decline in the resident's elimination status and did not develop a plan of care to address the incontinence. The RN also stated the Fall log was reviewed; however, no care plan had been developed to address the resident's recent falls. In addition, RN #3 stated no care plan had been developed to address the use of the psychotropic medication since the RN had not identified the medication was a new drug for resident #6. RN #3 stated he/she was not responsible for the development of the nutritional care plans. An interview conducted with the Dietary Manager (DM) on August 12, 2010, at 4:00 p.m., revealed the DM was responsible to develop a care plan related to significant weight changes. The DM stated he/she was aware of the weight increase; however, no care plan had been developed to address the significant weight increase for resident #6.	F 279	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* F – 282 1. The fall mat for resident #8 was returned to the resident's room and placed at the bedside on August 13, 2010 by LPN. The toileting plans for residents #9, 11, and 13 were reviewed on September 7, 2010 by ADON and updated. The SRNA care plans were updated as well. These care plans were reviewed with each on coming shift X 6 shifts to ensure communication of the plan to the SRNA. 2. The care plans and NACP for all residents will be reviewed by ADON, DON, MDS Coordinator to ensure all care needs are addressed. All updates and changes will be in red to highlight these changes for the SRNA. In addition the toileting programs for all residents will be reviewed by ADON, Wound Care nurse by September 13, 2010 and any changes or updates will be made and care plans and NACP will be updated in red to highlight these changes. 3. All SRNA were re-educated on September 13,	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility	F 282		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185340	A. BUILDING _____ B. WING _____	08/12/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 282	Continued From page 21 must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide services to four (4) of nineteen (19) sampled residents (residents #8, #9, #11, and #13) in accordance with each resident's written plan of care. The facility failed to ensure a fall mat was placed at resident #8's bedside as directed by the plan of care. Residents #9, #11, and #13 had care plan interventions for a scheduled toileting program; however, there was no evidence the toileting program was consistently being provided for these residents. The findings include: 1. Review of the medical record revealed resident #8 was admitted to the facility on December 23, 2009, with diagnoses of Cerebrovascular Accident, Acute Psychotic Episode, Coronary Artery Disease, and Depression. Review of the quarterly Minimum Data Set (MDS) dated June 29, 2010, revealed the facility assessed resident #8 as being moderately impaired in daily decision-making. The facility also assessed resident #8 as being at risk for falls. Review of the record revealed resident #8's last fall occurred on June 23, 2010, at 1:09 a.m. Review of the comprehensive care plan dated December 31, 2009, revealed resident #8 was at risk for falls related to weakness, confusion, and	F 282	*This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Glasgow Health and Rehabilitation Facility agrees with the citations noted on the pages of this Statement of Deficiencies. Glasgow Health and Rehabilitation Facility maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care. Please accept this Plan of Correction as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. To remain in compliance with all Federal and State regulations, this facility has taken or will take the actions set forth in the following Plan of Correction.* 2010 by DON on the use of the NACP and updates. All nurses were re-educated on September 14, 2010 by DON regarding the updating of care plan, NACP and the communication of these updates to appropriate staff. 4. The MDS Coordinator will review 10 care plans and corresponding NACP each week to ensure that changes are being made as needed. Her reviews will be presented to the facility QA committee no less than quarterly for one year. 5. Completion date: 9/17/2010	

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F 282	Continued From page 22 restlessness. Review of the care plan interventions revealed a floor mat was to be placed at the bedside. Observation on August 10, 2010, at 5:15 p.m., and on August 11, 2010, at 10:50 a.m., 1:00 p.m., 1:30 p.m., and 2:30 p.m., while resident #8 was in bed, revealed staff had failed to place a floor mat at resident #8's bedside. Further observation on August 11, 2010, at 4:30 p.m., revealed staff placed a fall mat at the resident's bedside, after surveyor intervention. Interview on August 11, 2010, at 4:55 p.m., with LPN #1 revealed LPN #1 was responsible to ensure care was provided for resident #8 and that the fall mat was at the bedside. LPN #1 stated resident #1 had the fall mat in the past and could not provide an explanation for the fall mat not being at the bedside during the survey. Interview on August 11, 2010, at 4:55 p.m., with CNA #4 who was responsible for resident #8's care, revealed CNA #4 had been employed at the facility for two weeks. CNA #4 stated each CNA was aware of the requirement to review the resident's Nurse Aide Care Plan at the first of each shift to inform what care the residents assigned to each CNA would require. CNA #4 stated the fall mat for resident #8 had been pushed under the resident's bed due to getting the resident up in a geri-chair. Observation with the CNA revealed the fall mat was not under resident #8's bed. Interview on August 11, 2010, at 5:05 p.m., with resident #8's wife revealed resident #8 had voided on the mat approximately ten days ago and staff removed the mat to be cleaned; however, the mat was not replaced.	F 282		

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F 282	Continued From page 23 2. Resident #11 was admitted to the facility on April 22, 2010, with diagnoses of Alzheimer's with Psychosis, Panic Disorder, Chronic Kidney Disease, Hypertension, and Congestive Heart Failure. Resident #11 was observed on August 12, 2010, at 11:50 a.m., sitting in a wheelchair. The resident stated he/she was not always aware of the need to void and used briefs for incontinence management. The resident stated sometimes the resident was able to call staff to assist with using the bathroom facilities. A review of the admission comprehensive assessment completed on May 4, 2010, revealed resident #11 was assessed to require extensive assistance with transfers and toileting and to be frequently incontinent of bowel/bladder. A review of the care plan for resident #11 revealed a scheduled toileting program was to be implemented on April 29, 2010. Resident #11 was to be toileted upon arising, before/after meals, and at bedtime. An interview conducted with Certified Nurse Aide (CNA) #4 on August 12, 2010, at 2:30 p.m., revealed the resident's individual toileting needs/programs would be identified on the CNA care plan. CNA #4 stated scheduled toileting attempts and results were required to be documented in the KIOS system. CNA #4 stated resident #11 was not on a scheduled toileting program. CNA #4 stated incontinence rounds were made every two hours and resident #11 was usually wet when checked.	F 282		

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F 282	Continued From page 24 CNA #3 stated in an interview conducted on April 12, 2010, at 2:45 p.m., that resident #11 was not on a toileting program and was usually wet when incontinent rounds were made. A review of the Bowel/Bladder detail report dated July 14, 2010 through August 12, 2010, revealed documentation that resident #11 had been toileted per staff five times in July 2010 (July 18, 2010, at 2:22 p.m. and 9:46 p.m., July 19, 2010, at 12:23 p.m., July 21, 2010, at 9:16 p.m., and July 23, 2010, at 9:10 p.m.). During August 2010 staff documented resident #11 was toileted four times (August 1, 2010, at 3:02 p.m., August 9, 2010, at 7:35 p.m., August 11, 2010, at 9:03 p.m., and August 12, 2010, at 10:17 a.m.). An interview conducted with the Director of Nurses (DON) on August 12, 2010, at 6:30 p.m., revealed the CNAs were responsible to review the CNA care plan to identify the resident's individualized needs. The DON stated he/she monitored the staff to ensure care plan interventions were being implemented, but was not aware the scheduled toileting program was not being followed for resident #11. 3. Resident #9 was admitted to the facility on April 30, 2007, with diagnoses to include Hemiplegia, Cerebral Vascular Accident, Insomnia, Anxiety State, Depressive Disorder, Mental Disorder, and Dementia without Behaviors. Record review of Minimum Data Set (MDS) assessment completed on March 31, 2010, revealed resident #9's bladder/bowel assessment as "tends to be incontinent daily, but some control present." Resident #9's care plan	F 282		

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F 282	Continued From page 25 updated June 30, 2010, revealed resident #9 was frequently incontinent of bowel and bladder and was on a scheduled toileting program; toilet after lunch, before and after supper, at bedtime, and at least once throughout the night. Additional record review of the nurse aide care plan for resident #9 revealed resident #9 was on a scheduled toileting program. An interview conducted on August 11, 2010, at 3:40 p.m., with CNA #5 revealed resident #9 usually rang the call bell after the resident had an incontinence episode and requested to be changed. CNA #5 revealed the CNA was unaware that resident #9 was on a scheduled toileting program. CNA #5 stated the CNA had not reviewed the nurse aide care plan prior to providing care to resident #9. Additional interview conducted with LPN #2 on August 11, 2010, at 3:55 p.m., revealed the LPN was responsible to monitor care provided by CNAs. LPN #2 stated the CNA should sign off on the CNA worksheet at the end of each shift to verify the nurse aide care plan was followed. LPN #2 further stated the LPN performed walking rounds at various times throughout the shift to ensure the CNAs have performed care. LPN #2 was unaware CNA #5 failed to provide scheduled toileting for resident #9. An interview conducted with the Director of Nursing (DON) revealed the CNAs were in-serviced on the resident toileting program with initial orientation. The DON further stated residents were assessed and care planned to alert staff of residents who required a scheduled toileting program.	F 282		